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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

#### IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 0014	4753		II. CERTI	IFICATION BY AUTHORIZED FACILITY OFFICER
	Facility Name: TWIN WILLOWS NURSI	ING CENTER			
	Address: Box 370	Salem	62881	I hav	ve examined the contents of the accompanying report to the of Illinois, for the period from 01-01-01 to 12-31-01
	Number	City	Zip Code	and cer	rtify to the best of my knowledge and belief that the said contents
	County: Marion				e, accurate and complete statements in accordance with able instructions. Declaration of preparer (other than provider)
	Telephone Number: (618) 548-0542	Fax # (618) 548-5893			ed on all information of which preparer has any knowledge.
	•	144 (010) 510 5070			ntional misrepresentation or falsification of any information
	IDPA ID Number: 37-098-7942001			in this	cost report may be punishable by fine and/or imprisonment.
	<b>Date of Initial License for Current Owners:</b>	5/2/73			(Signed) 3-30-02
	Type of Ownership:			Officer or Administrator	(Date) (Type or Print Name) Todd Curtis Woodruff
	Type of Ownership.			of Provider	(Type of Trine Name) Toda Cards Woodran
	VOLUNTARY,NON-PROFIT	X PROPRIETARY	GOVERNMENTAL		(Title) Administrator
	Charitable Corp.	Individual	State		
	Trust	Partnership	County		(Signed)
	IRS Exemption Code	X Corporation	Other	Paid	(Date)
		"Sub-S" Corp. Limited Liability Co.		Preparer	and Title)
		Trust		Перагег	
		Other			(Firm Name
					& Address)
					(Telephone) ( ) Fax # ( )
	In the event there are further questions about the	his ranget plagse contact			MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID
	Name: Todd Woodruff	Telephone Number: (618) 54	8-0542		201 S. Grand Avenue East
					Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Faci	lity Name & ID Numb	oer TWIN WILL	LOWS NURSING C	ENTER			# 0014753 Report Period Beginning: 01-01-01 Ending: 12-31-01
	III. STATISTICA	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/o	certification level(s) o	f care; enter number	of beds/bed days,			(Do not include bed-hold days in Section B.)
	(must agree	with license). Date of	change in licensed b	eds	76		<u> </u>
	(			_	-	_	E. List all services provided by your facility for non-patients.
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
					<del>'</del>		(E.g., day care, means on wheers, outpatient therapy)
	Beds at				Licensed		
	Beginning of	Licensu	ra	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census?  Yes
	Report Period	Level of		Report Period	Report Period		r. Does the facility maintain a daily infulight census.
	Report Period	Level of	Care	Report Periou	Report Period		C. D 2 6 Ab de la company for constitue of
_		01 W 1 (0N)	5)			+-	G. Do pages 3 & 4 include expenses for services or
1		Skilled (SNI				1	investments not directly related to patient care?
2			atric (SNF/PED)		27.740	2	YES NO X
3	76	Intermediat	\ /	76	27,740	3	
4		Intermediat				4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5		Sheltered C				5	YES X NO
6		ICF/DD 16	or Less			6	I On what data did you start providing long town care at this location?
_	7.0	TOTALC		7.0	27.740	1 -	I. On what date did you start providing long term care at this location?
7	76	TOTALS		76	27,740	7	Date started <u>01/10/73</u>
	D.C. E.						J. Was the facility purchased or leased after January 1, 1978?
	B. Census-For	the entire report per					YES Date NO X
	1	2	3	4	5		
	Level of Care	•	by Level of Care an	d Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
		Public Aid					YES NO X If YES, enter number
		Recipient	Private Pay	Other	Total		of beds certified and days of care provided
8	SNF					8	
9	SNF/PED					9	Medicare Intermediary
_	ICF	15,891	4,564		20,455	10	
11	ICF/DD					11	IV. ACCOUNTING BASIS
12	SC					12	MODIFIED
13	DD 16 OR LESS					13	ACCRUAL X CASH* CASH*
14	TOTALS	15,891	4,564		20,455	14	Is your fiscal year identical to your tax year? YES NO
	C Damas 4 Os	cupancy. (Column 5,	line 14 divided best	tal liaansad			Tax Year: 01/01/2001 Fiscal Year: 12/31/2001
		n line 7, column 4.)	73.74%	tai neenseu			* All facilities other than governmental must report on the accrual basis.
	bed days of	/, column 4.)	15.14/0	_			An inclines vener than governmental must report on the accidal basis.

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Page 3 12-31-01 Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 **Report Period Beginning:** 01-01-01 **Ending:** 

	V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)											
			osts Per Genera	- 0		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	110,079	15,603	4,377	130,059		130,059		130,059			1
2	Food Purchase		134,803		134,803		134,803	(149)	134,654			2
3	Housekeeping	50,102	11,353		61,455		61,455		61,455			3
4	Laundry	25,455	6,687		32,142		32,142		32,142			4
5	Heat and Other Utilities			49,105	49,105		49,105	(960)	48,145			5
6	Maintenance	24,059	12,819	14,742	51,620		51,620		51,620			6
7	Other (specify):*											7
8	TOTAL General Services	209,695	181,265	68,224	459,184		459,184	(1,109)	458,075			8
	B. Health Care and Programs											
-	Medical Director											9
10	Nursing and Medical Records	559,684	33,998	6,787	600,469		600,469		600,469			10
10a	Therapy											10a
11	Activities	34,268	3,747		38,015		38,015		38,015			11
12	Social Services	14,071		2,771	16,842		16,842		16,842			12
13	Nurse Aide Training	11,303	938	4,023	16,264		16,264		16,264			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	619,326	38,683	13,581	671,590		671,590		671,590			16
	C. General Administration											
17	Administrative	45,000			45,000		45,000		45,000			17
18	Directors Fees											18
19	Professional Services			42,339	42,339		42,339	(17,700)	24,639			19
20	Dues, Fees, Subscriptions & Promotions			5,976	5,976		5,976		5,976			20
21	Clerical & General Office Expenses		10,754	4,727	15,481		15,481		15,481			21
22	Employee Benefits & Payroll Taxes			125,406	125,406		125,406		125,406			22
23	Inservice Training & Education			İ								23
24	Travel and Seminar			962	962		962		962			24
25	Other Admin. Staff Transportation			1,206	1,206		1,206		1,206			25
26	Insurance-Prop.Liab.Malpractice			34,141	34,141		34,141		34,141			26
	Other (specify):*								·			27
28	TOTAL General Administration	45,000	10,754	214,757	270,511		270,511	(17,700)	252,811			28
20	TOTAL Operating Expense	874,021	230,702	296,562	1,401,285		1,401,285	(18,809)	1,382,476			29
29	(sum of lines 8, 16 & 28)						1,401,200	(10,009)	1,304,470		l	29

\*\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

TWIN WILLOWS NURSING CENTER

#0014753

**Report Period Beginning:** 

01-01-01 Ending:

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# V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			32,713	32,713		32,713		32,713			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,175	22,175		22,175	(22,175)				32
33	Real Estate Taxes			25,759	25,759		25,759		25,759			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Rent Storg Space			1,200	1,200		1,200		1,200			36
37	TOTAL Ownership			81,847	81,847		81,847	(22,175)	59,672			37
	Ancillary Expense											4
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		9,271		9,271		9,271		9,271			41
42	Provider Participation Fee			41,610	41,610		41,610		41,610			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		9,271	41,610	50,881	•	50,881		50,881	•		44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	874,021	239,973	420,019	1,534,013		1,534,013	(40,984)	1,493,029			45

<sup>\*</sup>Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

01-01-01

Ending:

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Facility Name & ID Number TWIN WILLOWS NURSING CENTER

VI. ADJUSTMENT DETAIL

# 0014753

Report Period Beginning:

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	In column	2 below, reference the		hich the particul	lar cos
	NON-ALLOWABLE EXPENSES	1 Amount	Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(960)	5-7		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(22,175)	32-7		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(149)	2-7		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(17,700)	19-7		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
	Income Taxes and Illinois Personal				1
26	Property Replacement Tax				26
	Nurse Aide Training for Non-Employees				27
	Yellow Page Advertising				28
	Other-Attach Schedule			1	29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (40,984)	)	\$	30

	OHF USE ONL	Y				
48		49	50	51	52	

# B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (40,984)		37

<sup>\*</sup>These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions)

(56	e instructions.)	1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

#### STATE OF ILLINOIS

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# TWIN WILLOWS NURSING CENTER

| ID# | 0014753 | Report Period Beginning: 01-01-01 | Ending: 12-31-01

Sch. V Line

	NON-ALLOWABLE EXPENSES	Amount	Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				
16				15
				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
				33
33				
				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49
7/	10001			7/

STATE OF ILLINOIS Summary A 01-01-01 Ending: 12-31-01

Facility Name & ID Number TWIN WILLOWS NURSING CENTER SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I # 0014753 Report Period Beginning:

													SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	<b>6E</b>	6F	6 <b>G</b>	6Н	<b>6</b> I	(to Sch V, col	.7)
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14		0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS Summary B # 0014753 Report Period Beginning: 01-01-01 Ending: Facility Name & ID Number TWIN WILLOWS NURSING CENTER 12-31-01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Conital Forman	PAGES	PAGE	SUMMARY TOTALS										
	Capital Expense		_		_	_				_	_			_
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6Н	61	(to Sch V, col.	_
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	45

#### VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

A. Litter below the names of ALL	ominoro ana roi	atou organiza	ations (partico) as asimoa in the	111301 40010113. 7	Attuon ui	i additional sonead		,·	
1			2				3		
OWNERS			RELATED NURSING HOME	ES		OTHER REL	ATED BUSINES	S ENTITII	ES
Name	Ownership %	Name		City		Name	City		Type of Business
Helen Woodruff	95					<b>Motel Developments</b>	Salem		Motel
Jeffrey Woodruff	5					Woodruff Services	Carbondale		Air Cond/Heating
					•				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V	11	Flower for resident Xmas	320	Jeffery Woodruff	5.00%	320		2
3	V	36	Office Storage	1,200	Motel Developments	100.00%	1,200		3
4	V	32	Interest	16,776	Todd Woodriff	0.00%	16,776		4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			<b>\$</b> 18,296			\$ 18,296	s *	14

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7 TWIN WILLOWS NURSING CENTER 0014753 **Report Period Beginning:** 12-31-01 Facility Name & ID Number 01-01-01 **Ending:** 

# VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6	<u> </u>	7		8	
						Average Hou	rs Per Work				
					Compensation	Week Devo	oted to this	Compensati	on Included	Schedule V.	
					Received	Facility and	% of Total	in Costs	for this	Line &	
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Todd Woodruff	Administrator	Management	0.00		60	100.00	Interest	\$ 16,776	32	1
2	Todd Woodruff	Administrator	Management	0.00		60	100.00	Salary	45,000	17	2
3	Helen Woodruff	Audit Accounting	<b>Audit Accounting</b>	95.00		20	30.00	Fees	23,500	19	3
4	<b>Hubert Woodruff</b>	Attorney	Legal Mgmt	0.00		5	10.00	Fees	17,700	19	4
5	Jeffrey Woodruff	Woodruff Services	Heating/Air	5.00				Sale of	320	11	5
6								Flowers			6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 103,296		13

<sup>\*</sup> If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

<sup>\*\*</sup> This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

~~		~~	 ****	~
. I .	<b>Д</b> I Н	OH	 INOI	`

Page 8 STATE OF ILLINOIS # 0014753 Report Period Beginning: 01-01-01 Facility Name & ID Number TWIN WILLOWS NURSING CENTER Ending: 12-31-01

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II. ALLOCATION OF INDIRECT COSTS	
	Name of Related Organization
A. Are there any costs included in this report which were derived from allocations of central office	Street Address
or parent organization costs? (See instructions.)  YES NO X	City / State / Zip Code
<del></del>	Phone Number ( )
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			1			\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11 12
12										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		<b>S</b>	25

# 0014753

Report Period Beginning: 01-01-0

01-01-01 Ending:

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## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

Facility Name & ID Number

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	•	3	4	5	,	6	7	8	9	10	
	Name of Lender	Relate YES		Purpose of Loan	Monthly Payment Required	Date of Note		Amou Original	nt of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related				•								
	Long-Term												
1	Bonds			Working Capital			\$	8,000		12-31-84	10.0000		1
2	Bonds			Purchase Factory		11-2-72		36,450	5,150	12-31-84	10.0000	515	2
3	Todd Woodruff			Working Capital		1-87		191,726	208,502	12-31-02	8.7500	16,776	3
4	Bank of Christopher			Working Capital	\$3,450.00	10-23-96		290,000		9-23-02	9.7500	131	4
5													5
	Working Capital												
6	Finance Charges											942	6
7	Accounts Payable												7
8													8
9	TOTAL Facility Related				\$3,450.00		\$	526,176	\$ 221,652			\$ 19,164	9
	B. Non-Facility Related*												
10	See original document			Purchase Office Bldg	\$3,577.00	4-1-86		195,455	21,509	12-31-93	14.0000	3,011	10
11				216 S. Broadway									11
12													12
13													13
14	TOTAL Non-Facility Related				\$3,577.00		\$	195,455	\$ 21,509			\$ 3,011	14
15	TOTALS (line 9+line14)						\$	721,631	\$ 243,161			\$ 22,175	15

<sup>\*</sup> Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

<sup>\*\*</sup> If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS

# 0014753 Report Period Beginning: 01-01-01 Ending: 12-31-01

Facility Name & ID Number TWIN WILLOWS NURSING CENTER

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

**B. Real Estate Taxes** 

						$\overline{}$
	Important, please see the next worksheet,	"RE_Tax". The real e	estate tax statement and			t
. Real Estate Tax accrual used on 2000 report.	bill must accompany the cost report.			s	24,723	
. Real Estate Taxes paid during the year: (Indicate the	ax year to which this payment applies. If payment cove	ers more than one year, det	ail below.)	\$	24,716	
. Under or (over) accrual (line 2 minus line 1).				\$	(7)	)
4. Real Estate Tax accrual used for 2001 report. (Detai	and explain your calculation of this accrual on the line	s below.)		\$	25,759	
5. Direct costs of an appeal of tax assessments which ha (Describe appeal cost below. Attach copi	s NOT been included in professional fees or other genees of invoices to support the cost and a co	1 0		\$		
6. Subtract a refund of real estate taxes. You must offse classified as a real estate tax cost plus one-half of any TOTAL REFUND \$ For 19	remaining refund.	al estate tax appeal	poard's decision.)	\$		
7. Real Estate Tax expense reported on Schedule V, line	33. This should be a combination of lines 3 thru 6.			s	25,759	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year: 199			FOR OHF USE ONLY			Τ
199 <sup>°</sup> 199		13	FROM R. E. TAX STATEMENT FOR 2	2000 <b>s</b>		
199 200	23,673 11	14	PLUS APPEAL COST FROM LINE 5	s		Ť
2000 001 based on amount of increase in tax paid from 99-200		14	PLUS APPEAL COST FROM LINE 5	3		t
		15	LESS REFUND FROM LINE 6	\$		1
			AMOUNT TO USE FOR RATE CALCU			

NOTES:

- 1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
  application for real estate tax exemption unless the building is rented from a for-profit entity.
  This denial must be no more than four years old at the time the cost report is filed.

#### IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

#### 2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME	TWIN WILLO	WS NURSING	CENTER		COUNTY	Marion	
FAC	ILITY IDPH LICE	NSE NUMBER	0014753		_			
CON	TACT PERSON R	EGARDING TH	HIS REPORT T	Todd Woodruff				
TEL	EPHONE (618) 54	18-0542	·-	FAX#:	(618) 548-5	893		
A.	Summary of Rea	l Estate Tax Co	<u>st</u>					
	cost that applies to home property wh	o the operation of nich is vacant, ren	f the nursing ho nted to other org	essed for 2000 on the me in Column D. Re ganizations, or used for period other than cal	al estate tax or purposes o	applicable to other than long	any portion	of the nursing
	(A)			(B)		(C)		(D)
	Tax Index !	<u>Number</u>	Prope	rty Description		Total Tax		Tax Applicable to Nursing Home
1.	11-02-000-027		PT SE NE		\$	24,716.20	\$_	24,716.20
2.					\$		\$_	
3.					\$		\$_	
4.					\$		\$	
5.					\$		\$_	
6.					\$		\$_	
7.					. \$		_ \$_	
8.					\$		\$_	
9.					\$		\$_	
10.					. \$_		- \$_	
				TOTALS	s_	24,716.20	s_	24,716.20
B.	Real Estate Tax	Cost Allocations	<u>s</u>					
	Does any portion used for nursing h		ply to more thar	one nursing home, v		ty, or propert	y which is n	ot directly
				shows the calculation				

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which

C. Tax Bills

is normally paid during 2001.

Page 10A

	ity Name & ID Number TWIN WILL UILDING AND GENERAL INFORM		S	TATE OF ILLINOIS # 0014753	S Report Period Beginning:	01-01-01 Ending:	Page 11 12-31-01
A.	Square Feet: 16,205	B. General Construction Typ	e: Exterior <u>B</u>	Brick	Frame Fireproof Constru	Number of Stories	1
C.	Does the Operating Entity?	X (a) Own the Facility	(b) Rent from a	Related Organization	ı. [	(c) Rent from Completely Unre	lated
	(Facilities checking (a) or (b) must c	omplete Schedule XI. Those checking	g (c) may complete Schedule	XI or Schedule XII-A	A. See instructions.)	<b></b>	
D.	Does the Operating Entity?	X (a) Own the Equipment	(b) Rent equipm	ent from a Related O	organization.	(c) Rent equipment from Comp Unrelated Organization.	letely
	(Facilities checking (a) or (b) must c	omplete Schedule XI-C. Those check	ing (c) may complete Schedu	le XI-C or Schedule	XII-B. See instructions.)	0 0 0 - <b>g</b>	
Е.	(such as, but not limited to, apartme	d by this operating entity or related to ents, assisted living facilities, day train quare footage, and number of beds/un	ning facilities, day care, inde	pendent living faciliti			
F.	Does this cost report reflect any org If so, please complete the following:	anization or pre-operating costs whic	ch are being amortized?		YES [	X NO	
1.	. Total Amount Incurred:		2	. Number of Years O	ver Which it is Being Amortiz	ed:	
3.	. Current Period Amortization:		4	. Dates Incurred:			
		Nature of Costs: (Attach a complete schedule	detailing the total amount of	organization and pro	e-operating costs.)		
XI. (	OWNERSHIP COSTS:						
	A. Land.	1 Use	2 Square Feet	3 Year Acquired	4 Cost		

87,000

28,000

1 2 3

1 Facili 2 3 TOTALS

# 0014753

Report Period Beginning:

01-01-01 Ending:

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	1 Beds*	ng Depreciation-Including Fixed Eq FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Deus		1973	1966	\$ 380,183	\$ 11,406	33 1/3	\$ 11,406	S	\$ 330,774	4
5			2970	1,00	<del>* ***********************************</del>	4 11,100	55 175	4 11,100	Ψ	000,771	5
6											6
7											7
8											8
	Impro	vement Type**									_
9		7.									9
10											10
11											11
12 R	Roof			1976	27,500		10				12
	Vater Heater			1977	1,024		10			1,024	13
	ire Exit Ligh			1978	695		5			695	14
	Emergency Po			1978	1,695		5			1,695	15
	Emergency Po	ower		1979	1,359		5			1,359	16
	Compressor			1979	372		5			372	17
	Battery Units			1980	570		3			570	18
	Compressor			1980 1981	533 780		5			533 780	19
	Mixing Valve Central Air			1981	771		10 10			771	20 21
	Jentral Air Disposal Kitch	100		1981	745		10			745	22
	Storage Shed	ien		1982	600		8			600	23
	Heat Pumps			1983	2,245		10			2,245	24
	Phone System			1985	3,318		20			3,318	25
	Heat Pumps			1985	1,400		8			1,400	26
27 L	Driveway			1988	2,767		3			2,767	27
28 S	Seal Coat/Pate	ch Driveway		1997	1,850		3			1,850	28
29 I	Oor Monitor	System		1999	7,590		10	759	759	1,708	29
		System - 3 ton		1999	12,588		5	2,518	2,518	5,350	30
	Replacement 1			1999	64,580		15	4,305	4,305	8,969	31
		Coat Driveway		1999	16,136		8	2,017	2,017	4,286	32
	Outside Walk			1999	600		5	120	120	295	33
34 R	Replace South	Wing Sewer Line		2000	1,046		10	105	105	166	34
	Replace Three	e Outside Hydrants		2000	525		10	52	52	56	35
36											36

See Page 12A, Line 70 for total

<sup>\*</sup>Total beds on this schedule must agree with page 2.
\*\*Improvement type must be detailed in order for the cost report to be considered complete.

# 0014753

Report Period Beginning:

01-01-01 Ending:

Page 12A 12-31-01

B. Building Depreciation-Including Fixed Equipment. (See i	nstructions.) Roun	d all numbers to nea	rest dollar.					
1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37		S	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 531,472	\$ 11,406		\$ 21,282	\$ 9,876	\$ 372,328	70

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

STATE	OF	ш	IN	OIS

Page 13 Facility Name & ID Number TWIN WILLOWS NURSING CENTER 0014753 Report Period Beginning: 01-01-01 **Ending:** 12-31-01

#### XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	ĺ	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 94,922	\$ 11,230	\$ 11,230	\$		\$ 11,230	71
72	Current Year Purchases	2,578	201	201		8	201	72
73	Fully Depreciated Assets	79,445					79,445	73
74								74
75	TOTALS	\$ 176,945	\$ 11,431	\$ 11,431	\$		\$ 90,876	75

D. Vehicle Depreciation (See instructions.)\*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76		Wagon 87	1987	\$ 10,990	\$	\$	\$	4	\$ 10,990	76
77										77
78										78
79										79
80	TOTALS			\$ 10,990	\$	\$	\$		\$ 10,990	80

E. Summary of Care-Related Assets

**Accumulated Depreciation** 

Reference Amount (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable) Total Historical Cost 81 719,841 81 (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable) **Current Book Depreciation** 32,713 82 Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable) 32,713 83 84 (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable) 84 Adjustments

(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current B	ook	Acc	cumulated	
	Description & Year Acquired	Cost	Depreciat	ion 3	Dej	oreciation 4	
86	Alumelite Trailer	\$ 10,000	\$		\$	10,000	86
87	216 S Broadway	56,000				56,000	87
88	Schedule	19,807		501		11,061	88
89	Driveway 216	6,520		652		818	89
90				·			90
91	TOTALS	\$ 92,327	\$	1,153	\$	77,879	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

514,668

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

						STA	TE OF ILLINOIS						Page 14
Faci	lity Name & I	D Number	TWIN WILLOWS	NURSING CE	NTER	#	0014753	Rep	port Period Be	ginning:	01-01-01	Ending:	12-31-01
XII.	1. Name of 1 2. Does the	and Fixed Equip Party Holding		lopments-Rents	Office/Storage Space amount shown below or	ı line 7	y, column 4?  YES  X	NO					
		1 Year Constructed	2 Number d of Beds	3 Date of Lease	4 Rental Amount		5 Total Years of Lease	6 Total Years Renewal Optic	~				
3 4 5 6	Original Building: Additions			\$	1,200	)			3 4 5 6	Beginning Ending	01-01-01 12-31-01 e paid in future	_	
7	TOTAL			S	1,200	)			7	rental agi		years under t	ne current
	This amo by the le	ount was calculaingth of the leas		al amount to be  X NO T	amortized erms:		*			Fiscal Yea  12. 13. 14.	/2002 /2003 /2004	Annual Ro \$ 1,200 \$	ent
	15. Îs Mova	ble equipment	rental included in buil vable equipment: \$		Description:		YES X						
	C. Vehicle R	ental (See instr	uctions.)				(Attach a schedule	e detailing the bi	reakdown of n	iovable equipmo	ent)		
	1		2 Model Year	M	3 Ionthly Lease		4 Rental Expense						
17 18	Use		and Make	\$	Payment	\$	for this Period	17 18			is an option to borovide complet le.		
19								19		44.701			6.1
20	TOTAL			\$		\$		20			nount plus any a must agree wit		

			S	TATE OF ILLI	NOIS						Page 15
Facility Name & ID Number	TWIN WILLOWS NUI	RSING CENTER			#	0014753	Report Perio	od Beginning:	01-01-01	Ending:	12-31-01
XIII. EXPENSES RELATING	TO NURSE AIDE TRAINING P	PROGRAMS (See in	structions.)			_					
A. TYPE OF TRAINING	PROGRAM (If aides are trained	in another facility	program, attach a s	schedule listing t	the facility	name, address	and cost per	aide trained in th	nat facility.)		
1. HAVE YOU TRA DURING THIS F		X YES 2.	CLASSROOM	PORTION:			3.	CLINICAL PO	RTION:	_	
PERIOD?	KEFORT	NO NO	IN-HOUSE PR	OGRAM				IN-HOUSE PR	OGRAM		
If "ves" nlease co	omplete the remainder		IN OTHER FA	CILITY				IN OTHER FA	CILITY	X	
of this schedule. I	f "no", provide an why this training was		COMMUNITY	COLLEGE	X			HOURS PER A	IDE		
not necessary.	,g		HOURS PER A	AIDE							
B. EXPENSES		ALLOCATI	ON OF COSTS	(d)			C. CON	NTRACTUAL IN	NCOME		
		1	2	3		4		In the box below facility received			
	·	Fa	cility			<u> </u>				_	
		Drop-outs	Completed	Contract		Total		\$			
1 Community College	Tuition	\$ <b>287</b>	<b>\$</b> 3,186	\$	\$	3,473					
2 Books and Supplies		91	847			938	D. NUN	MBER OF AIDE	S TRAINED		
3 Classroom Wages	(a)	202	8,841			9,043					
4 Clinical Wages	(b)	50	2,210			2,260		COMPLET	ED		

550

15,634

630

16,264

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(c)

(e)

5 In-House Trainer Wages

Contractual Payments

Nurse Aide Competency Tests

SUM OF line 9, col. 1 and 2

6 Transportation

TOTALS

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

TOTAL TRAINED

550

16,264

. From this facility

DROP-OUTS

1. From this facility

2. From other facilities (f)

2. From other facilities (f)

11

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
  (f) Attach a schedule of the facility names and addresses
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	(	1	2	3	4	5	6	7	8	
		Schedule V	Stafi	Î	Outsid	e Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other th	nan consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. $3 + 5 + 6$ )	
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
	Licensed Speech and Language									
2	Development Therapist	10-3	hrs		6	412		6	412	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy		prescrpts							9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)	10-3	hrs		6	600		6	600	10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	12	\$ 1,012	\$	12	\$ 1,012	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Ility Name & ID Number TWIN WILLOWS NURSING CENTER

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached. Facility Name & ID Number

0014753 As of 12-31-01

Report Period Beginning:

(last day of reporting year)

	-	1		2 After	
		0	perating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	280,064	\$	1
2	Cash-Patient Deposits				2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance )		355,482		3
4	Supply Inventory (priced at )		12,500		4
5	Short-Term Investments		11,691		5
6	Prepaid Insurance		27,000		6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)		116,000		8
9	Other(specify): 1120 Tax Deposits		38,650		9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	841,387	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable		40,100		11
12	Long-Term Investments				12
13	Land		32,000		13
14	Buildings, at Historical Cost		436,183		14
15	Leasehold Improvements, at Historical Cost		88,807		15
16	Equipment, at Historical Cost		255,722		16
17	Accumulated Depreciation (book methods)		514,668		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify):				23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	338,144	\$	24
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	s	1,179,531	\$	25
	Town or most to unu # 1)	Ψ	-,11,7,001	ΙΨ	

		1	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	88,350	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits				28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		25,200		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		2,900		31
32	Accrued Real Estate Taxes(Sch.IX-B)		25,759		32
33	Accrued Interest Payable				33
34	Deferred Compensation				34
35	Federal and State Income Taxes		3,995		35
	Other Current Liabilities(specify):				
36					36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	146,204	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable		387,424		39
40	Mortgage Payable				40
41	Bonds Payable		13,150		41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43	Stock		3,500		43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$	404,074	\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	550,278	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	629,253	\$	47
	TOTAL LIABILITIES AND EQUITY				
48	(sum of lines 46 and 47)	\$	1,179,531	\$	48

01-01-01

<sup>\*(</sup>See instructions.)

Facility Name & ID Number TWIN WILLOWS NURSING CENTER
XVI. STATEMENT OF CHANGES IN EQUITY

0014753

Report Period Beginning: 01-01-01

	10010
Ending:	12-31-

			1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	549,981	1
2	Restatements (describe):			2
3				3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	549,981	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		13,375	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	(	)	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe) Adjusting Balance Sheet		65,897	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	79,272	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	629,253	24

<sup>\*</sup> This must agree with page 17, line 47.

**Report Period Beginning:** 

01-01-01 Ending:

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

28a

29

30

7,200

1,579,636

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care	- I I I I I I I I I I I I I I I I I I I	
1	Gross Revenue All Levels of Care	\$ 1,540,270	1
2	Discounts and Allowances for all Levels	(5,709)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,534,561	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	10,856	11
12	Gift and Coffee Shop	7,439	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,323	14
15	Telephone, Television and Radio	466	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	162	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 20,246	23
	D. Non-Operating Revenue		
	Contributions	222	24
	Interest and Other Investment Income***	17,407	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,629	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	216 Rental	7,200	28

29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)

30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)

28a

		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	458,075	31
32	Health Care	671,590	32
33	General Administration	252,811	33
	B. Capital Expense		
34	Ownership	59,672	34
	C. Ancillary Expense		
35	Special Cost Centers	9,271	35
36	Provider Participation Fee	41,610	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,493,029	40
41	Income before Income Taxes (line 30 minus line 40)**	86,607	41
42	Income Taxes	3,995	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 13,375	43

*	This mus	t agree with	page 4,	line 45, colum	n 4.
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2

12-31-01

Page 19

<sup>\*\*</sup> Does this agree with taxable income (loss) per Federal Income
Tax Return? No If not, please attach a reconciliation.

<sup>\*\*\*</sup> See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

<sup>\*\*\*\*</sup>Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number TWIN WILLOWS NURSING CENTER

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	2,080	2,226	\$ 45,350	\$ 20.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,776	7,141	112,106	15.69	3
4	Licensed Practical Nurses	7,331	8,312	105,624	12.70	4
5	Nurse Aides & Orderlies	41,403	42,877	283,497	6.61	5
6	Nurse Aide Trainees	2,078	2,078	11,303	5.44	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,568	1,776	12,051	6.79	9
	Activity Assistants	3,453	3,668	22,217	6.06	10
11	Social Service Workers	1,807	1,897	14,071	7.42	11
	Dietician					12
	Food Service Supervisor					13
14	Head Cook	2,978	3,180	26,407	8.30	14
	Cook Helpers/Assistants	7,078	7,163	46,020	6.42	15
	Dishwashers	5,861	6,298	37,652	5.98	16
	Maintenance Workers	1,935	2,282	24,059	10.54	17
	Housekeepers	7,831	8,279	50,102	6.05	18
19	Laundry	3,624	4,038	25,455	6.30	19
20	Administrator	3,000	3,040	45,000	14.80	20
	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,784	1,917	13,107	6.84	31
32	Other Health Care(specify)	ĺ		,		32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	100,587	106,172	s 874,021 *	\$ 8.23	34

<sup>\*</sup> This total must agree with page 4, column 1, line 45.

## B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	110	s 4,377	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	975	10-3	39
40	Physical Therapy Consultant	36	3,600	10-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	49	2,771	12-3	45
46	Other(specify)				46
47	Advisory Physician	12	1,200	10-3	47
48					48
49	TOTAL (lines 35 - 48)	243	s 12,923		49

# C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53
	•				

<sup>\*\*</sup> See instructions.

					ST	ATE OF ILLINOIS					Pa	ge 21
	<u>WIN WILLOWS N</u>	URSING (	CENT	TER	#_ 00	014753	Rep	ort Period Beg	inning:	01-01-01	Ending:	12-31-01
XIX. SUPPORT SCHEDULES					In n n a				Inn.			
A. Administrative Salaries	E	Ownershi	ip		D. Employee Benefits and				F. Dues,	Fees, Subscriptions	and Promotions	
Name	Function	%	•	Amount		scription	•	Amount	IDDII I	Description		Amount
Todd Woodruff	Administrator		_ \$_	45,000	Workers' Compensation		\$_	46,662		cense Fee	S	200
					Unemployment Compens	sation insurance		6,914		ing: Employee Recr are Worker Backgi		806
					Employee Health Insura			66,863		# of checks perform		492
					Employee Health Insural	nce			IHCA	# of checks periori	<u>ieu 31</u> )	4 121
					Illinois Municipal Retire				IL Secy S	4-4-		4,131
						ment Fund (IMRF)"		2 927	MES	tate		
TOTAL (agree to Schedule V, line	17 asl 1)				Xmas Employee Recognition			2,827 1,168	WILS			287
(List each licensed administrator se			¢	45,000	Bottle Water			972	-			
B. Administrative - Other	parately.)			45,000	bottle water			912				
B. Administrative - Other									Logge Dr	ublic Relations Exp		
Description				Amount						on-allowable adverti		
Description			e.	Amount						llow page advertisi	`	
									Ye	enow page advertish	<u>1g</u> (	
					TOTAL (agree to Sched	ule V	•	125,406		TOTAL (agree t	o Sch V S	5,976
					line 22, col.8)	uic v,	Ψ=	123,400		line 20, o		3,770
TOTAL (agree to Schedule V, line	17 col 3)				E. Schedule of Non-Cash	Compensation Paid			G Sched	ule of Travel and So		
(Attach a copy of any management	· · · · · · · · · · · · · · · · · · ·		Ψ=		to Owners or Employe				G. Sched	uic of fraverand S	, minai	
C. Professional Services	service agreement)				to Owners or Employe	ees				Description		Amount
Vendor/Payee	Type			Amount	Description	Line #		Amount		Description		Amount
Hubert Woodruff	Legal Manageme	ant.	e	17,700	Description	Line #	s	Amount	Out of St	tate Travel	•	
Helen Woodruff	Audit-Accountin		_ J	23,500			_ "-		Jui-01-31	IAIL TTAVEL		
H & R Block	Tax Return	5		900					-			
ATT Legal	Tax Return			239					In-State	Traval		
ATT Legal	-			239		<del></del>			III-State	TTAVCI		
									Seminar	Evnonco		962
									Seminar	Expense		902
									Entout-:	nment Expense		
TOTAL (agree to Schedule V, line	10 column 3)				TOTAL		•		Lutertain	agree to So	h V	
(If total legal fees exceed \$2500 atta			\$	42,339	IOIAL		Φ.		TOTAL	line 24, co		962
i totai iegai iees exceeu 52500 atta	ich copy of involces	• )	D.	42,339	1				IUIAL	nne 24, co	1. O) 3	

<sup>\*</sup> Attach copy of IMRF notifications

<sup>\*\*</sup>See instructions.

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			004	4

Page 22 12-31-01 Facility Name & ID Number TWIN WILLOWS NURSING CENTER Report Period Beginning: Ending: 01-01-01 0014753

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

	(See instructions.)				o (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		50 , , (	,, con e ,.					
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year					_	Amount of	Expense Amor	tized Per Year			
	Improvement	Improvement	Total Cost	Useful	TT 14000	TT 14 000		TT 12.004	*****		TT 1000 4	*****	**************************************
<b></b>	Type	Was Made		Life	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
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17													
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19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number TWIN WILLOWS NURSING CENTER  (A Fra there are not provided by a related party and the location of this expense of this correspond of the services and the location of this expense of this correspond of the services and the location of this correspond of this correspond of the services and the location of this correspond of the services of				OF ILLINOIS		04 04 04		Page 23
(1) Are nursing employees (RN, LPN, NA) represented by a union?  (2) Are there any dues to nursing home associations included on the cost report?  (3) Did the nursing home make political contributions or payments to a political action organization?  (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?  (5) Have you properly capitalized all major repairs and equipment purchases?  (6) Indicate the total amount of both disposable and non-disposable during this period?  (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?  (8) Are you presently operating under a sale and leaseback arrangement?  (9) Are you presently operating under a sale and leaseback arrangement?  (9) Are you presently operating under a sublease agreement?  (9) Are you presently operating under a sublease agreement?  (9) Are you presently operating under a sublease agreement?  (9) Are you presently operating under a sublease agreement?  (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?  (11) Indicate the amount of the Provider Participation Fees paid and accruated to the Department of Public Aid. Aid during this cost report period.  (12) Are there any sulary costs which have been allocated to more than one line on Schedule V for an individual employee?  (12) Are there any sulary costs which have been allocated to more than one line on Schedule V for an individual employee?  (12) Are there any sulary costs which have been allocated to more than one line on Schedule V for an individual employee?  (12) Are there any sulary costs which have been allocated to more than one line on Schedule V for an individual employee?  (13) Indicate the amount of the provider Participation Fees paid and accruated to the Department of Public Aid during this cost report period.  (14) Is an an addit been proposed which are period of the cost report of all trace Vespense relates to the pro			#	# 0014753	Report Period Beginning:	01-01-01	Ending:	12-31-01
22 Are there any dues to nursing home associations included on the cost report? Yes If YES, give association name and amount. IIICA \$4,131			(12)	II	1: 4:	- 4 414	. 1 1.:11 - 3 4 -	
Are there any dues to nursing home associations included on the cost report? Yes If YES, give association name and amount. If If CA \$4.131	(1)	Are nursing employees (KN,LPN,NA) represented by a union?	(13)					
If YES, give association name and amount. IIICA \$4.131  (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes and of the fiscal year? No If YES, what is the capacity? Yes What was the average life used for new equipment added during this period? What was the average life used for new equipment added during this period? What was the average life used for new equipment added during this period? What was the average life used for new equipment added during this period? What was the average life used for new equipment added during this period? What was the average life used for new equipment added during this period? What was the average life used for new equipment added during this period? What was the average life used for new equipment added during this period? What was the average life used for new equipment added during this period? What was the average life used for new equipment added during this period? What was the average life used for new equipment added during this period? What was the average life used for new equipment added during this period? What was the average life used for new equipment added during this period? What was the average life used for new equipment added during this period? What was the average life used for new equipment added during this period? What was the average life used for new equipment added during this period? What was the average life used for new equipment added during this period. So are the costs included for out-of-state trave? No If YES, please included to such a program during distribution of new tension of the use of the cost report period. So are the cost of community in the period. So and the cost of the provider period of the cost report? Yes If YES, please indicate the amount of the Cost report?  (10) Was this home previously operated by a related party (as is defined in the instructions for the cost report? Yes If YES, attach a comple	(2)	Are there any dues to nursing home associations included on the cost report? Yes				ate, been prope	eriy ciassified	
Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes   If YES, and the secosts been properly adjusted out of the cost report? Yes   If YES, what is the capacity of the building differ from the number of bods licensed at the end of the fiscal year? No If YES, what is the capacity? If YES, what is the eapacity? If YES, what is the eapacity?   Ves   If YES, what is the eapacity?   Ves   What was the average life used for new equipment added during this period?   Ves   What was the average life used for new equipment duelded during this period?   Ves   Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. S 7,998   Line   Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. S 7,998   Line   Indicate the total amount of both disposable and non-disposable diaper expense and the location of this form been determined using accounting procedures consistent with prior reports? Yes   If NO, at If YES, places indicate the amount of incorned are as all and leaseback arrangement? No   If YES, places indicate the amount of incorne earned from such a program during this reporting period. S   If YES, places indicate the amount of incorne earned from such a program during this reporting the inglit and all other times when not in use? No   If YES, places indicate the amount of incorne earned from providing such transportation of nurses and patients? Less than d. Have vehicle usage logs been maintained? No   If YES, places indicate the amount of incorne earned from providing such transportation of the cost feeded the nurse provided at the nursing home during the night and all other times when not in use?   No   If YES, places indicate the amount of incorne earned from providing such transportation during this reporting period. S   If YES, places indicate the amount of i				•		_		
action organization? Yes If YES, have these costs been properly adjusted out of the cost report?  Ves  If YES, what is the capacity?  So have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?  Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7.998			(14)	Is a portion of the	building used for any function other	than long term	care services	for
action organization? Yes If YES, have these costs been properly adjusted out of the cost report?  Yes  (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?  (5) Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?  (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,998	(3)	Did the nursing home make political contributions or payments to a political	` ′	the patient census	listed on page 2, Section B? No	Ü	For exampl	e,
a schedule which explains how all related costs were allocated to these functions.  (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?  (5) Have you properly capitalized all major repairs and equipment purchase? Yes What was the average life used for new equipment added during this period?  (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,998 Line 10 Line	` '			is a portion of the	building used for rental, a pharmacy	day care, etc.	) If YES, attac	eĥ
(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?  (5) Have you properly capitalized all major repairs and equipment purchases?  What was the average life used for new equipment added during this period?  (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. S 7,998 Line 10  (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.  (8) Are you presently operating under a sale and leaseback arrangement? No If YES, give effective date of lease.  (9) Are you presently operating under a sublease agreement? YES X NO X If YES, please indicate name of this related party (as is defined in the instructions for Schedule VIII? YES NO X If YES, please indicate the amount of the cost report yeriod. S 41,610  (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VIII? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. S 41,610  This amount is to be recorded on line 42 of Schedule V. Yes If YES, attach an explanation of the allocation.  (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.				a schedule which	explains how all related costs were a	llocated to thes	se functions	
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